

HOME AND COMMUNITY BASED SERVICES ELDERLY WAIVER INFORMATION PACKET

The Medicaid Home and Community Based Services Elderly Waiver (HCBS Elderly) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

GENERAL PARAMETERS

- Elderly Waiver services are individualized to meet the needs of each member. The following services are available:
 - **Adult Day Care**
 - **Assistive Devices**
 - **Assisted Living on-call**
 - **Case Management**
 - **Chore Services**
 - **Consumer Directed Attendant Care**
 - **Emergency Response System**
 - **Home and Vehicle Modifications**
 - **Home Delivered Meals**
 - **Home Health Aide**
 - **Homemaker Services**
 - **Mental Health Outreach**
 - **Nursing Care**
 - **Nutritional Counseling**
 - **Respite**
 - **Senior Companions**
 - **Transportation**
 - **Consumer Choices Option**
- The services, which are considered necessary and appropriate for the member, will be determined through an interdisciplinary team consisting of the member; case manager/DHS service worker, service provider(s) and other persons the member chooses.
- All members will have a comprehensive service plan developed by a case manager in cooperation with the member. A case manager/DHS service worker prior to implementation of services must sign and date the comprehensive service plan. The member must receive case management services.
- Members shall access all other services for which they are eligible and which are appropriate to meet their needs as a precondition of eligibility for the Elderly Waiver.
- A comprehensive service plan must be developed and reviewed annually with the interdisciplinary team and signed by the case manager/DHS social worker.
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive Elderly Waiver services; an approved Elderly Waiver service provider must be available to provide those services.
- Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.
- Elderly waiver services cannot be provided when a person is an inpatient of a medical institution.
- Members must need and use one billable Elderly Waiver service during each calendar quarter.

- The total costs of Elderly Waiver services cannot exceed the following:
 - Nursing Level of Care \$1339.00 per month
 - Skilled Level of Care \$2765.00 per month
- Following is the hierarchy for accessing waiver services:
 - Private insurance
 - Medicaid
 - Elderly Waiver services
- In addition to services available through the Elderly Waiver assistance may be available through the In-Home Health Related Care program and or the Rent Subsidy Program through the Iowa Finance Authority. Members may contact the Iowa Finance Authority at 1-800-432-7230.

MEMBER ELIGIBILITY CRITERIA

Members may be eligible for HCBS Elderly Waiver services by meeting the following criteria:

- Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States
- Be 65 years of age or older
- Be determined eligible for Medicaid (Title XIX) *as if* the member was in a medical institution. Members may be Medicaid eligible prior to accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the member has previously been determined ineligible
- Be determined by the Iowa Medicaid Enterprise, Medical Services to need Nursing **or** Skilled level of care

SERVICE DESCRIPTIONS

- **PLEASE NOTE:**
Elderly Waiver services are individualized to meet the needs of each member. However, decisions regarding what services are appropriate, the numbers of units or the dollar amounts of the appropriate services are based on the member's needs as determined by the member and an interdisciplinary team.

ADULT DAY CARE

- WHAT:** Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center.
- WHERE:** Adult day care program in the community certified to provide Elderly Waiver services
- UNITS:** A unit is:

Hourly
or
Half day - 1 to 4 hours
or
Full day - 4 to 8 hours
or
Extended day - 8 to 12 hours

ASSISTIVE DEVICES

- WHAT:** Assistive devices are practical equipment products to assist members with activities of daily living and instrumental activities of daily living, which allow the member more independence. These assistive devices may include but are not limited to: long reach brush; extra long shoehorn; non-slip grippers to pick up and reach items; dressing aids; shampoo rinse tray; inflatable shampoo tray; double handled cup and sipper lid.
- WHERE:** In the member's home. Not the provider's home.
- UNIT:** A unit is the cost of one item.
- MAXIMUM UNIT:** The cost of any one assistive device cannot exceed \$115.62 per unit

CASE MANAGEMENT SERVICES

- WHAT:** The goal of case management is to enhance the member's ability to exercise choices, make decisions, and take risks that are typical of life, and fully participate in the community.
- Case management activities include the following:
- A comprehensive diagnosis and evaluation
 - Assistance in obtaining appropriate services and living arrangements
 - Coordination of service delivery
 - Ongoing monitoring of the appropriateness of services and living arrangements
 - Crisis assistance to facilitate referral to the appropriate providers
- WHERE:** In the member's home and community. Not in the provider's home.
- UNIT:** A unit is a monthly reimbursement.

CHORE SERVICES

- WHAT:** Chore services are limited to the following services:
- Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
 - Minor repairs to walls, floors, stairs, railings and handles;
 - Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
 - Lawn mowing and removal of snow and ice from sidewalks and driveways.
- Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.
- WHERE:** In and on the outside of the home and on the member's property
- UNIT:** A unit is 15 minutes.

CONSUMER DIRECTED ATTENDANT CARE (CDAC)

WHAT: Assistance to the member with self-care tasks, which the member would typically do independently if the member was otherwise able. An individual or agency, depending on the member's needs may provide the service. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be done under the supervision of a professional registered nurse or licensed therapist working under the direction of a physician. The registered nurse or therapist shall retain accountability for actions that are delegated.

Skilled services may include but are not limited to: Tube feedings, intravenous therapy, parenteral injections, catheterizations, respiratory care, care of decubiti & other ulcerated areas, rehabilitation services, colostomy care, care of medical conditions out of control, postsurgical nursing care, monitoring medications, preparing and monitoring response to therapeutic diets, and recording and reporting of changes in vital signs.

Non-skilled services may include but are not limited to: Dressing, hygiene, grooming, bathing supports, wheelchair transfer, ambulation and mobility, toileting assistance, meal preparation, cooking, eating and feeding, housekeeping, medications ordinarily self-administered, minor wound care, employment support, cognitive assistance, fostering communication, and transportation.

A determination must be made regarding what services will benefit and assist the member. Those services will be recorded in The HCBS Consumer Directed Attendant Care Agreement Form 470-3372. This Agreement becomes part of the comprehensive service plan developed for the member. This form must be signed and dated by the member, case manager, service worker and provider before any services are provided

This service is only appropriate if the member parent, guardian, or attorney in fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

WHERE: In the member's home or community. Not the provider's home.

DOES NOT INCLUDE: Daycare, respite, room and board, case management or supervision

CDAC cannot replace a less expensive service.

An individual CDAC provider cannot be the recipient of respite services provided on behalf of a member receiving HCBS Elderly services.

The cost of nurse supervision, if needed

UNITS: A unit is:
a 15-minute unit.

MAXIMUM UNITS: The CM working with the member and the interdisciplinary team, establishes an amount of dollars that may be used for CDAC. The amount is then entered into the comprehensive service plan along with information about other HCBS services the member may receive. This monetary information is also entered into The HCBS Consumer Directed Attendant Care Agreement Form 470-3372 along with the responsibilities of the member and the provider and the activities for which the provider will be reimbursed. The member and the provider come to agreement on the cost per unit. A completed copy of the Agreement is distributed to the member, the provider and the case manager. The Agreement becomes part of the comprehensive service plan. These steps must be completed **prior to** service provision.

The case manager should be aware of and have knowledge of the specific services included in the assisted living facility contract to ensure the following:

- That assisted living facility services are not duplicative of CDAC services
- Knowledge of how member needs are being addressed
- Awareness of member unmet needs that must be included in the comprehensive service plan
- CDAC payment does not include costs of room and board

- Each member must be determined by Iowa Medicaid Enterprise to meet nursing level of care.
- The CDAC fee is calculated based on the needs of the member and may differ from individual to individual

**PROVIDER
ENROLL:**

The provider must be enrolled with the Department's fiscal agent and certified as a CDAC provider prior to the completion of the HCBS Consumer Directed Attendant Care Agreement.

It may be important for the member to enlist more than one CDAC provider. Back up services may be necessary in case of an emergency.

BILLING:

The member as well as the provider must sign the Claim for Targeted Medical Care before it is submitted for payment. This verifies that the services were provided as shown on the billing form.

EMERGENCY RESPONSE SYSTEM

WHAT:

An electronic device connected to a 24-hour staffed system which allows the member to access assistance in the event of an emergency

WHERE:

The emergency response system is connected to the member's home phone and includes a portable emergency button carried by the member.

UNITS:

A unit is:

- One time installation fee
- and/or**
- One month of service

**MAXIMUM
UNITS:**

12 months of service per State fiscal year (July 1-June 30)
The case manager member or the member's, should inform Providers of the ERS Representative as soon as possible when the service is no longer needed.

HOME AND VEHICLE MODIFICATION (HVM)

WHAT:

Physical modifications to the home and/or vehicle to assist with the health, safety and welfare needs of the member and to increase or maintain independence. Competitive bids are essential to determine the cost effectiveness of the projector item. All modification requests are reviewed individually and a determination is made regarding the appropriateness of the modification request.

WHERE:

In/on the member's home and/or vehicle. **Please note that only the following modifications are included:**

1. Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens
2. Bathtubs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible showers and sink areas
3. Grab bars and handrails
4. Turnaround space adaptations
5. Ramps, lifts, and door, hall and window widening
6. Fire safety alarm equipment specific for disability
7. Voice activated, sound activated, light activated, motion activated and electronic devices directly related to the member's disability
8. Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle
9. Keyless entry systems
10. Automatic opening device for home or vehicle door
11. Special door and window locks
12. Specialized doorknobs and handles
13. Plexiglas replacement for glass windows
14. Modification of existing stairs to widen, lower, raise or enclose open stairs
15. Motion detectors
16. Low pile carpeting or slip resistant flooring
17. Telecommunications device for people who are deaf
18. Exterior hard surface pathway

19. New door opening
20. Pocket doors
21. Installation or relocation of controls, outlets, switches
22. Air conditioning and air filtering if medically necessary
23. Heightening of existing garage door opening to accommodate modified van

DOES NOT INCLUDE: Modifications which increase the square footage of the home, items for replacement which are the responsibility of the homeowner/landlord, vehicle purchase, fences, furnaces or any modifications or adaptations available through regular Medicaid.

Purchasing, leasing or repairs of a motorized vehicle are excluded.

UNIT: A unit is the cost of the completed modification or adaptation.

MAXIMUM: The maximum lifetime benefit is \$1061.11. This is not included in the monthly total.

HOME DELIVERED MEALS

WHAT: Home-delivered meals are prepared outside of the member's home and delivered to the member.

Each meal must ensure that the member receives a minimum of one-third of the daily-recommended dietary allowance as established by the Food and Nutrition Research Council of the National Academy of Sciences. Each meal may also be a liquid supplement, which meets the minimum one-third standard.

When a restaurant provides home delivered meals, a nutritional consultation must be completed. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance. Members must inform their case manager/DHS social worker and provider of home delivered meals immediately if they no longer need the service

WHERE: Delivered to the member's home

UNIT: A unit is one meal.

MAXIMUM UNITS: Fourteen (14) meals may be delivered during any week.

HOME HEALTH AIDE (HHA)

WHAT: Unskilled medical services, which provide direct personal care. This service may include observation and reporting of physical or emotional needs, assisting with bathing, shampoo, oral hygiene, toileting, ambulation, helping individuals in and out of bed, reestablishing activities of daily living, assisting with oral medications ordinarily self administered and ordered by a physician, performing incidental household services which are essential to the individual's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

Home health aide as a waiver service may be accessed *after* accessing services under the Medicaid State plan.

WHERE: In the member's home. Not the provider's home.

DOES NOT INCLUDE: Homemaker services such as cooking and cleaning or services, which meet the intermittent guidelines.

May not duplicate any regular Medicaid or waiver services provided under the state plan.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

UNIT: A unit is a visit.

HOMEMAKER

WHAT: Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance. Homemaker service is limited to the following components: Essential shopping; limited house cleaning,

WHERE: In the member's home and community. Not the provider's home.

UNIT: A unit is 15 minutes.
Homemaker services must be billed in whole units. Partial hours are not available.

MENTAL HEALTH OUTREACH

WHAT: Services provided in a member's home to identify, evaluate and provide treatment and psychosocial support.
The services can be provided only on the basis of a referral from Case Management

WHERE: In the member's home. Not the provider's home.

UNIT: A unit is a 15-minute increment.

MAXIMUM UNITS: 1440 units (360 hours) per year

NURSING CARE

WHAT: Nursing care services are services provided by a licensed nurse. The services are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medication; intravenous, hypodermocysis and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the member's condition and needs.

WHERE: In the member's home. Not the provider's home.

DOES NOT INCLUDE: Nursing services provided outside of the home or services which meet the intermittent guidelines.

Medicaid intermittent coverage: Regular Medicaid provides for intermittent coverage of skilled nursing and home health aide services provided in the person's home for both children and adults. Services are usually provided two to three hours per day for two to three days per week. Intermittent skilled nursing coverage includes visits up to five days per week and daily or multiple daily visits for wound care or insulin injections. Intermittent home health aide coverage includes visits twice per day up to seven days per week for persons attending school or working or when ordered by the physician and included in the plan of care, not to exceed 28 hours per week.

UNIT: A unit is 15 minutes.

MAXIMUM UNITS: Intermediate level of care - 8 nursing visits per month
Skilled level of care No maximum number of visits per month

NUTRITIONAL COUNSELING

WHAT: Nutritional counseling for a severe nutritional problem or condition, which is beyond standard medical management

WHERE: In the member's home. Not the provider's home.

UNIT: A unit is a 15-minute increment.

RESPITE

WHAT: Respite care services are services provided to the member that gives temporary relief to the usual caregiver and provides all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the member to remain in their current living situation.

- **Specialized respite** means respite provided on a staff to member ratio of one to one or higher for individuals with specialized medical needs requiring monitoring or supervision provided by a licensed registered nurse or licensed practical nurse.
- **Group respite** means respite provided on a staff to member ratio of less than one to one.
- **Basic individual respite** means respite provided on a staff to member ratio of one to one or higher for individuals without specialized medical needs that would require care by a licensed registered nurse or licensed practical nurse.

WHERE: Respite may be provided in the member's home, another family's home, camps, organized community programs (YMCA, recreation centers, senior citizens centers, etc.), ICF/MR, RCF/MR, hospital, nursing facility, skilled nursing facility, assisted living program, adult day care center, foster group care, foster family home or DHS licensed daycare.

Respite provided outside the member's home or outside a facility in locations covered by the facility's licensure, certification, accreditation, or contract must be approved by the parent, guardian, or primary caregiver and interdisciplinary team, and must be consistent with the way the location is used by the general public. Respite in these locations may not exceed seventy-two (72) continuous hours.

DOES NOT INCLUDE: Services shall not be reimbursable if the living unit is otherwise reserved for persons on a temporary leave of absence.

Respite cannot to be provided to members residing in the family, guardian or usual caregiver's home during the hours in which the usual caregiver is employed unless it is in a camp setting.

Respite shall not be simultaneously reimbursed or provided with duplicative services under the waiver.

UNITS: A unit is 15 minutes. Services are limited by the monthly maximum available for all waiver services.

MAXIMUM UNITS: Fourteen consecutive days of 24-hour respite care may be reimbursed
and

Respite services provided to three or more individuals for a period exceeding 24 consecutive hours for individuals who require nursing care because of a mental or physical condition must be provided by a licensed health care facility as described in the Iowa Code chapter 135C.

SENIOR COMPANIONS

WHAT: A companion who provides non-medical care supervision, oversight and respite. Senior companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks.

WHERE: In the member's home. Not the provider's home.

DOES NOT INCLUDE: Hands on nursing or medical care

UNIT: A unit is one hour.

TRANSPORTATION

- WHAT:** Transportation services may be provided for members to conduct business errands, to complete essential shopping, to receive medical services not reimbursed through medical transportation and to reduce social isolation.
- WHERE:** In the community as identified in the comprehensive service plan
- UNITS:** The units are as follows:
Per mile or per one way trip
- The amount approved in the comprehensive service plan determines the limit. The limit amount is determined by the member's needs.

CONSUMER CHOICES OPTION

- WHAT:** The **Consumer Choices Option** is an option that is available under the "fill in the blank of your favorite waiver here" This option will give you more control over a targeted amount of Medicaid dollars. You will use these dollars to develop an individual budget plan to meet your needs by directly hiring employees and/or purchasing other goods and services.
- The **Consumer Choices Option** offers more choice, control and flexibility over your services as well as more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees. You will also work with a Financial Management Service that will manage your budget for you and pay your workers on your behalf. Contact your case manager/service worker for more information. Additional information may also be found at the website: www.ime.state.ia.us/HCBS/HCBSConsumerOptions.html
- Services that may be included in the individual budget under the Consumer Choices Option are:
- Assistive Devices
 - Chore Services
 - Consumer Directed Attendant Care Attendant (Unskilled)
 - Home and Vehicle modification
 - Home delivered meals
 - Homemaker Service
 - Basic Individual Respite Care
 - Senior Companion
 - Transportation
- WHERE:** In the member's home or community. Not the provider's home.
- DOES NOT INCLUDE:** Consumer Choices option cannot be used to pay for room and board, workshop services, E other childcare and personal entertainment items. Goods and services provided. Consumer Choices option cannot otherwise be provided through Medicaid state plan services. Goods and services would decrease the need for other Medicaid services; and/or promote inclusion in the community; and/or increases your safety in your home and community.
- UNITS:** A monthly budget amount is set for each member

APPLICATION PROCESS

The application process for the Elderly Waiver requires a coordinated effort between the Department of Human Services and non-Department agencies on behalf of the prospective member. If you are currently working with Department of Human Services personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance worker, DHS service worker or a case manager/DHS social worker. This will decrease the amount of time needed to complete the application process and assist in communication.

1. Application for Medicaid (Title XIX) and the Elderly Waiver is made with an Income Maintenance worker (IM) at the local DHS office.
 - An appointment will be scheduled with the IM. The documentation requested to bring to this appointment may include:
 - Financial records
 - Title XIX card
 - Letter of Medicaid eligibility
 - Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.
2. For all new applicants to the Elderly Waiver and annually thereafter, a Level of Care Certification form (470-4392) must be completed by a medical professional. The income maintenance worker or the case manager may give this form to the member. In most cases the case manager coordinates the completion of the certification form by the medical professional, member or family member. This form is submitted via fax by the case manager or medical professional to the Iowa Medicaid Enterprise Medical Services Unit Nurse Reviewer.
3. The case manager will follow up to ensure that the IME Nurse Reviewer receives the documentation.
4. The case manager/DHS service worker will complete the Home and Community Based Services Assessment or Reassessment form 470-4694.
5. The Iowa Medicaid Enterprise, Medical Services will review the HCBS Assessment/Reassessment to determine if member needs require intermediate or skilled level of care.
 - If the member does not meet level of care, the IM will send a Notice of Decision notifying the member of the denial. The member has the right to appeal the decision. The appeal process is explained on the Notice of Decision.
6. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided and the provider(s) of the services. The interdisciplinary team meeting will be attended by the member the case manager/DHS service worker, and other support persons the member may choose to attend. The end result of the interdisciplinary team decisions will be a comprehensive service plan developed by the case manager/DHS service worker
7. The case manager's dated signature on the comprehensive service plan indicates the member's approval for Elderly Waiver services.